Committee Members Present:
Mr. Edward Barlow, Chair
Ms. Jean Grim
Ms. Mary Wallace
Mr. Carlton Starke
Mr. Daniel Moore

Human Rights Advocate Representation:
Beverly Garnes, Human Rights Manager

Crater LHRC Secretary
Ms. Fabri D. Claiborne

Committee Members Absent:
Ms. Audrey Wood
Mrs. Mary T. Kindred

Affiliates Present:

- ✓ *Mr. James Scott III,*
  Adult Activity Services
- ✓ *Patricia Tucker*
  Agape Unlimited Inc. I, New Beginning, Inc., Phoenix-N-Peace
- ✓ *Mr. Clarence Dilworth,*
  Benchmark Residential Services & Dan-Poe-Dil, Inc.
- ✓ *Ms. Peggy Ball,*
  DePaul Community Resources
- ✓ *Ms. Serressa Burgess*
  John Randolph Medical Center
- ✓ *Ms. Cynthia Batts, Chandra Batts-Stephenson,*
  Low Ground Visions, Inc. /Day Support
- ✓ *Ms. Felicia Daniels,*
  Progressive Adult Rehabilitation Center, Inc. (P.A.R.C.)
- ✓ *Ms. Jeronica Page,*
  Pryor House, High Hopes
- ✓ *Ms. Sandra McCabe, Staff RN*
  Southside Regional Hospital Inpatient and Outpatient Services,
- ✓ *Mr. Robert Taylor, Michael Nicolas*
  Visions Family Services, Inc.
- ✓ *Ms. Janine Johnson*
  T'Lab
- ✓ *Beatrice Johnson,*
  Agape Unlimited II

Affiliates Present Con't

- ✓ *Christopher Brown*
  JC HomeLife

Affiliates Absent

Live 4 Life Inc.
New Hope Youth Services, LLC
Trucare Homes, LLC
Family and Youth Service

I. Call to Order

A quorum being present, Chair Edward Barlow called the Crater Local Human Rights Committee meeting to order at 5:35 PM at Taylor-Starkewood Enterprises 589 S. Crater Road, Petersburg, Virginia.

I. ***Public Comments:***

None

II. Approval of Minutes

A motion was made and seconded to approve the minutes of the Thursday, July 14, 2011 meeting with the corrected date affixed. . Ayes: Ms Mary Wallace. Mrs. Mary T. Kindred.

III. Advocate's Comments

a. Beverly Garnes discussed and passed out papers informing everyone of the time frames that have been established for submitting reports.

b. She informed everyone of the importance of maintaining all affiliate reports for three years and Human Rights' minutes are to be kept for five years.
   i. The report schedule will cover all four quarters

Quarter 1	January 1 – March 31
Quarter 2	April 1 – June 30
Quarter 3	July 1 – September 30
Quarter 4	October 1 – December 31
Annual Report	Due by January 15

c. A memorandum was emailed to each affiliate and copies were made available during the meeting in regards to the process for providers seeking DBHDS approval for the addition of a new location of a licensed service in the same region.

IV. Financial Report

Mr. Barlow reminded the members and providers that the State Human Rights guidelines were placed in effect as of July 1, 2011. As a part of the Cooperative Agreement the LHRC members can no longer make a motion to accept the financial report. The affiliates agreed that they would still like to receive a copy of the financial report, but remove the Financial Report from the agenda.

V. Secretarial Report

Ms. Fabri Claiborne reported on the Affiliate Submission Report Log for the fourth quarter. The Affiliate Submission Report Log reports the status of whether reports were submitted On Time, Late or Not Submitted at all.

On Time

- ✓ Adult Activity Services
- ✓ Agape' I Unlimited, Inc.
- ✓ Agape' II Unlimited, Inc.
- ✓ Benchmark
- ✓ Dan-Poe-Dil
- ✓ DePaul Community Resources
- ✓ High Hopes
- ✓ New Beginning
- ✓ Phoenix-N-Peace, Inc.
- ✓ Progressive Adult Rehabilitation Center, Inc.
- ✓ Pryor House
- ✓ Southside Regional Medical Center – Outpatient
- ✓ Southside Regional Medical Center Inpatient
- ✓ T'Lab, Inc.
- ✓ New Hope Youth Services, LLC

Late Submission

- ✓ John Randolph Medical Center
- ✓ Visions Family Services
- ✓ Low Ground Visions
- ✓ JC Home Life

No Report Submitted

- ✓ Live 4 Life, Inc.
- ✓ Family and Youth Services, Inc.
- ✓ TruCare Homes

VI. Old Business

a. Mr. Barlow brought it to everyone's attention that there was information inadvertently omitted from the Mays meeting minutes in regards to Progressive Adult Rehabilitation Center, Inc. The following information will be amended to the May 2011 minutes:

PARC Day Support: On April 12, 2011- Client fainted in Kmart while shopping on a trip. It appeared he hit his head on the checkout counter. No injuries were apparent when staff examined him. The staff member monitored the vital signs of the client until EMS responded. After being examined by the EMS, his signs checked to be normal. His blood sugar was 100. The necessary authorities were contacted. The EMS did not transport the client to the hospital, due to normal vital signs, therefore the staff member did. After being examined in the ER of Southside Regional Medical Center no injuries were found. There was no determination as to why the client fainted. A follow up was done on April 15, 2011.

Osage House – On March 9, 2011 – A routine bed check was conducted around 11:30pm. The client was observed on the floor beside his bed and C-PAC mask off of his face. Another staff member who went to his room between 11:10pm and 11:15pm, stated the client was fine, in his bed with the mask on. CPR was administered until the arrival of EMS. The client was transported to Southside Regional Medical Center where he was pronounced dead at 12:30am, reportedly of a heart attack. The necessary authorities were contacted.

Osage House – On March 18, 2011 – A staff member reported one of the clients was not feeling and complained of pain in side and back. Client was taken to Southside regional Medical Center by a staff member. The necessary authorities were contacted. Although the client was not admitted to the hospital, his blood pressure was low and diagnosed with pneumonia. The next day the client still was not well and did not want to eat breakfast. The client fell to the floor, a staff member checked for injuries. No visible injuries found. Staff was advised to transport client to the hospital where a CT scan and other test were performed. The client was admitted from 3/19/2011 - 4/1/2011. After being discharged from the hospital, the client was placed in Health South Rehabilitation Hospital for two weeks. Thus, returning to Osage House. Client received home health care until May 10¸2011.

VII. New Business

With the guidance of Mrs. Beverly Garnes, Mr. Barlow went over the new format of the Quarterly Activities Report and the Annual Report. He also reiterated the Quarterly Report submission dates for 2012.

VIII. Event Report Statistics

Reports from each provider on events occurring during the reporting period of July 1 – September 29, 2011.

a) **Adult Activity Services** -
No program changes or activity to report.

b) Agape Unlimited I
No activity to report

c) **Agape Unlimited II**
No activity or changes to report.

d) **Benchmark Residential Services**
No program changes.

Carson House
No activity or changes to report.

e) **Dan-Poe-Dil**
Wedgewood House
No activity or changes to report

Church Road House
No allegations to report.

Administrative Investigative Report

On September 10, 2011 a client became upset and threw a rock through the window and proceeded to punch out the broken glass with his fist. By doing so he sustained a laceration to his right wrist. EMS was called as well as the necessary authorities. The client stated to the program director and in the presence of EMS that the reason he broke the window was he was in the group home and not allowed to have a girlfriend or get married. Conclusion, the wounds were self inflicted not associated with abuse or neglect

On July 26, 2011 the residential staff stated that a client was having a behavioral emergency. While eating dinner he attempted to take a peer's drink. The peer resisted, thus being hit in the face. The peer ran and the client went after him. A staff member followed and intervened and was attacked by the client. The client went back in the home and engaged in property destruction, throwing and breaking chairs, turning the kitchen table over as well as furniture in the living room. The staff ensured other individuals were out of harm's way. 911 were called. The behavior continued until he punched the window out with left arm and sustained a laceration. The Dinwiddie County Sherriff's Department and stated due to the fact the client was deaf and nonverbal it was not appropriate to take him to jail. He was however transported to Southside Regional Medical Center, where he received six staples.

f) **DePaul Community Resources**
No Activity to report.

g) **High Hopes**
No activity or changes to report

h) JC Homelife
No activity to report

i) **John Randolph Medical Center** –

j) **Low Ground Visions, Inc**.
Residential Service
No activity to report. One resident deceased on September 3, 2011 due to an illness.

Day Support
No activity to report.

k) New Beginning, Inc.
On July 18, 2011 an individual ingested a decorative marble like object taken from a dish on the table in the waiting room of the dentist office. The individual was taken to John Randolph Medical Center. The x-ray conducted was clear. Physician said he will pass it through his bowels in a couple of days. Staff was alerted to report any sign of discomfort or changes in appetite.

On July 27, 2011 an individual hit his head on the bottom cabinet. He sustained a laceration on top of his head. He was taken to the emergency room of John Randolph Medical Center.

On August 2, 2011 an individual was seen by PCP due to swelling of right big toe and foot. He was diagnosed with cellulitis and gangrene of the right foot and was taken to John Randolph Medical Center.

On August 6, 2011 an individual fell off the van backwards hitting her head. The individual was taken to the emergency room at John Randolph Medical Center.

On August 22, 2011 individual was admitted to John Randolph Medical Center for signs of confusion – mixed matched shoes, urinating in his bed, her was unsteady, drowsy and drooling.

On August 27, 2011 an individual was taken to the emergency room of John Randolph Medical Center for striking his roommate in the facial area with a hamper. He was evaluated by the ER physician ; exhibited no aggressive

behavior, therefore deemed to be fine. A consultation and behavior specialist will be sought. First aid was administered to the victim, he was taken to John Randolph Medical Center. It was there an x-ray was obtained of his facial area. There was no fracture, but received eight sutures to hisx lip.

On September 7, 2011 – Individual was hospitalized due to a swollen knee. There was no report of injury. In the hospital he was diagnosed with arthritis.

On September 19, 2011 an individual was hospitalized for displaying uncharacteristic behaviors (talking loudly to himself, making threats to staff) He struck another peer for no reason.

On September 26, 2011. An individual was hospitalized for swelling in feet and legs.

On September 26, 2011. An individual left her day support building and entered a private home across the street. She was followed by staff who returned her to the home. From there she began hitting the walls, throwing furniture, hitting staff and banging her head. She also began eating paper from the wall, dirt and lint from between her toes. It was recommended by the psychiatrist to have her hospitalized.

l) New Hope Home
No activity to report

m) Phoenix-N-Peace, Inc.

HOPE Intensive Home:
No activity to report
Residential
On August 25, 2011 the client's leg was red and warm to the touch. He was taken to Dr. Durrani's office for an evaluation. He was later admitted to John Randolph Medical Center.

On August 28, 2011Eight individuals were exposed to carbon monoxide from the generator being used during the power outage that stemmed from the hurricane. The individuals were treated at Southside Regional Medical Center Emergency Room. Staff members during that time were found to be negligent by not reporting that the alarm was going off. Four staff members were suspended for three days and upon return will be retrained on emergency preparedness and carbon monoxide and smoke detectors use.

Day Support
On July 11, 2011 an individual bit off approximately one inch of another individual's tongue. The alleged abuser was sent to a psychiatrist and

admitted to John Randolph Medical Center for evaluation. The victim has been transferred to another residential and day support facility. The tongue has healed with no speech impairment.

n) **Progressive Adult Rehabilitation Center, Inc. (P.A.R.C.)** –

P.A.R.C Osage House

On August 3, 2011 the client reported to staff that he felt dizzy.
When questioned about other symptoms, client stated his head was also hurting.
Staff monitored and took the client to Southside Regional Medical Center Emergency room for evaluation. The necessary authorities were contacted. The client was diagnosed with an inner ear infection. Medication was prescribed

On August 6¸2011 Staff at Osage House reported that the client did not eat his lunch and did not appear to be feeling well. The client had remained in the bed for most of the day with one staff monitoring him in his room. Due to the fact that he has several documented medical problems, staff was instructed to transport him to Southside Regional Medical Center for evaluation. The necessary authorities were contacted. A condition could not be diagnosed. A follow up with PCP was recommended

On August 13, 2011, Staff reported that the client fell out of the bed while getting up on her own, while staff assisted another resident. When staff returned to client's room she was on her knees on the floor. Her C-PAC mask was still on her face. Staff noticed an abrasion on her forehead. The staff member cleaned the abrasion. At the recommendation of the Supervisor, the client was taken to the doctor's office as a precaution. The client has limited verbal skills. The necessary authorities were contacted. There was bruising to the client's face and the doctor stated all functions seemed to be normal.

P.A.R.C Day Support

On July 27, 2011 a client was knocked on the floor as another individual in day support was walking passed her while she was going back to her seat after using the restroom. The client was helped up from the floor and examined for any injuries. The primary care physician was contacted and she were taken to see him at 1:15pm. She was taken to the Appomattox Imaging for an X-ray in which was ordered.

On July 28, 2011 - The results from the x-ray was received. The results showed only injuries which had been healed from old wound.

Also, when the client arrived at PARC Services and her fingers were swollen (right ring and pinkie fingers). The doctor's office stated to apply an ice pack. Ice pack applied after 2 hours and fingers had not gone down. She was taken to Appomattox Imaging to have an X-ray of her right hand/fingers completed which was ordered by the doctor.

On July 29, 2011 The results from the X-ray showed fingers were not broken or fractured. Appointment was made with the orthopedic doctor for Monday.

On August 11, 2011 the client was taken to Dr. M, Orthopedic for swollen fingers. He ordered her to wear a split on fingers and keep arm/hand elevated.

P.A.R.C Supported Living Services
No Activity or Changes to Report

o) **Pryor House**
No Activities or Changes to report.

p) **Southside Regional Medical Center, Inpatient Services**
Each incident of restraints and seclusions were carefully monitored by a physician to ensure their safety and no harm to staff members.

A total of five (5) restraints and one (1) seclusion was done during the quarter.

July 2, 2011, 6:00am – 37 yr. old female was restrained for 4 hours and 15 minutes. She was aggressive, charged staff, kicked an LPN, and began throwing trash cans. Staff was unable to do a debriefing on the female patient because she was in a psychotic state. She was restrained until medication could take effect.

July 2, 2011, 4:10pm – 37 yr. old female was restrained for 14 ½ hours. She became quickly agitated, began threatening and fighting staff. A patient debriefing was unable to be conducted due to confusion and severe psychosis. Medication was continued regularly. Staff is working with the doctor on the effectiveness of the medication.

July 7, 2011, 12:15am – 37 yr. old female. Third restraint incident for female patient. She was restrained for 6 hours and 15 minutes. Patient is bipolar. She threw things at staff and threatened harm to them. PRN medication had already been administered for early signs of escalation, but no improvements. Patient is unable to be debriefed effectively.

July 15, 2011, 9:50am – 48 yr. old male was restrained for 1 hour and 55 minutes. He had paranoid schizophrenia. He threatened to hurt the nurse and damage the unit because he was not discharged as expected. During patient debriefing he apologized for behavior while in restraints. Staff was quick to react. Medication was effective.

July 15, 2011 11:15am – 55 yr. old female was placed in seclusion for 1 hour. She was paranoid with schizophrenia and became enraged when she was not discharged. She hit the walls and charged into the nurses' station, knocking over the computers. During patient debriefing she admitting being angry because she was not discharged.

September 3, 2011 7:00pm – 65 yr. old male was restrained for 3 hours. He came from the emergency room for being combative and threatened the

psych staff upon arrival. Staff was unable to do a patient debriefing. An emergency restraint was required. Restraints were removed after medication was given and took effect.

q) **Southside Regional Medical Center Outpatient Services** –
No activity or changes to report.

r) **T'LAB, Inc**.. –
No activity or changes to report.

s) Visions Family Services -

Residential

Four allegations
On June 26, 2011 upon the clients' arrival from day support, staff noticed bruising on his right arm. An investigation was conducted. The client is also nonverbal. He has a history of self-inflicted injuries.

On August 2, 2011 a resident became physically and verbally abusive toward staff and then left the home without permission. The client was found by Mr. Nichols. The client then ran to home of someone he did not know and began banging and kicking the door. The owner of the home opened the door. Mr. Nichols explained who the client was. The owner asked them to leave. The client spat in the owner's face and attempted to hit him. Mr. Nichols physically escorted the client from the property, at which time the client fell to the ground and stated Mr. Nichols broke his arm. The police and EMS was called and the client was taken to Southside Regional Medical Center. The client did sustain a fracture to his left arm. An investigation was conducted. The client, Mr. Nichols, and the owner of the home were all interviewed. It was determined there was not enough evidence to substantiate abuse.

On August 8, 2011 a resident of the Rockfield House was asked numerous times to get out of bed and each time the resident refused. When the resident did get up, he wanted a bacon and egg sandwich, but was told by staff it was too late to prepare that, but he could fix a sandwich so he would not be late for the day program. The resident became upset by this, tossing food to the floor and became verbally and physically aggressive. The TOVA method was used by staff member so that the resident could calm down. With the eggs on the floor, both the resident and staff member fell to the floor. The resident eventually calmed down and went about his daily routine.

The situation that occurred on August 8, 2011 occurred again on September 26, 2011. The resident did not want to get up nor take his medication. Therefore, becoming verbally abusive and smacked the

water bottle out of the staff's hand when attempting to administer his medication

There were a couple of suggestions given by fellow providers.

- ***Change the time medication is given to the resident at night.***
- ***Rather than argue with the resident about getting up and preparing breakfast. Prepare the breakfast ahead of time, therefore the resident will not be late for the van.***

Petersburg Community Integration Services
No activity or program changes

Intensive In-Home
No activity or program changes.

Therapeutic Day Treatment
No activity or program changes

IX. Announcements / Updates

The next regular scheduled meeting will be held Thursday, January 12 , 2012, 5:30 PM at Starkewood Counseling Services, 589 S. Crater Road, Petersburg, VA.

X. Other Actions

XI. ***Adjournment***

There being no further business, the meeting was adjourned at 7:45 PM.

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Edward W. Barlow, Chair (Date)